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## Administrative Regulations - Medicare - Medicare Provider Reimbursement Manual - Defeasance Losses

Eugene A. Vittone II

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ADMINISTRATIVE REGULATIONS—MEDICARE—MEDICARE PROVIDER REIMBURSEMENT MANUAL—DEFEASANCE LOSSES—The United States Supreme Court held that the Secretary of Health and Human Services is not bound to apply generally accepted accounting principles in calculating the amount which health care providers should receive under Medicare for reimbursement of bond defeasance losses.

*Shalala v. Guernsey Memorial Hospital*, 115 S. Ct. 1232 (1995).

Guernsey Memorial Hospital (“Guernsey”) refinanced bonded debt<sup>1</sup> which was originally issued in 1972 and 1982, to reduce its debt service burden.<sup>2</sup> Guernsey estimated that the refinancing of the bonded debt would save it twelve million dollars over the original term of the debt.<sup>3</sup> The refinancing of the debt would cause an immediate defeasance loss of \$672,581.<sup>4</sup> Guernsey believed that the Medicare program should be charged with an appropriate share of the loss.<sup>5</sup> Guernsey

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1. *Shalala v. Guernsey Memorial Hosp.*, 115 S. Ct. 1232, 1234 (1995). Bonded debt is a financing device in which an institution, such as a hospital, sells bonds to finance capital improvements. *Guernsey*, 115 S. Ct. at 1234.

2. *Id.* In refinancing the bonds, Guernsey tried to reduce the interest associated with the original bonds. *Id.* Many hospitals conducted this type of refinancing of bonded debt in order to “lock into” the low interest rates that were available in the early 1980’s and 1990’s. Dennis Barry, *Shalala v. Guernsey Memorial Hospital*, REIMBURSEMENT ADVISOR, April 1995, at 4.

3. *Guernsey*, 115 S. Ct. at 1234. See Brief for Petitioner at 22, *Guernsey* (No. 93-1251) (outlining the specific accounting of transactions involved in the case).

4. *Guernsey*, 115 S. Ct. at 1234. A defeasance loss is the paper loss that occurs with the refunding of bonds. SIDNEY DAVIDSON ET AL., FINANCIAL ACCOUNTING; AN INTRODUCTION TO CONCEPTS, METHODS, AND USES 441 (5th ed. 1988). A defeasance loss is usually offset by the increased revenue produced by refunding. *Id.* Defeasance losses occur through the refunding of bonds, typically an advanced refunding type of transaction. Robert L. Roth, *USSC Rules 5-4 that DHHS Secretary is Not Required to Follow GAAP in making Medicare Reimbursement Determinations*, HEALTH LAW DIGEST, April 1995, at 53. In an advanced refunding transaction, a hospital borrows money in order to pay off bonded debt before the debt matures, and issues new bonds. *Id.* The proceeds from the new debt are deposited into an irrevocable trusteed escrow account for the sole purpose of releasing the provider from any liability relating to the old debt. *Id.*

5. *Guernsey*, 115 S. Ct. at 1234. The Medicare program is the federal program that provides reimbursement of health care expenses of senior citizens and the disabled. See 42 U.S.C. § 1395 (1988). The Medicare program allows hospitals and participating providers to charge to the program an amount which is based on the

further believed that the portion chargeable to the Medicare program should be assessed within one year.<sup>6</sup> Guernsey's position was consistent with generally accepted accounting principles ("GAAP"),<sup>7</sup> an accrual accounting method.<sup>8</sup> The Secretary of Health and Human Services (the "Secretary"), who administers the Medicare program,<sup>9</sup> stated that the portion attributable to Medicare of the defeasance loss should be amortized over the normal term of the bonds.<sup>10</sup> Guernsey

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use of the health care facilities by program beneficiaries. *Id.* See *infra* note 35 for the relevant text of 42 U.S.C. § 1395 (1988).

6. *Guernsey*, 115 S. Ct. at 1234. Under the Medicare program reimbursement scheme, participating hospitals furnish services to program beneficiaries and are reimbursed by the Secretary of Health and Human Services through fiscal intermediaries. *Id.* at 1235. Fiscal intermediaries are groups which contract with the Health Care Financing Agency (the "HCFA") to administer the Medicare program locally. *Id.* This administration also includes making initial reimbursement decisions. *Id.* See 42 U.S.C. §§ 1395g, 1395h (1995). Hospitals are reimbursed for "reasonable costs," which are defined by the statute as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." *Guernsey*, 115 S. Ct. at 1235.

7. *Guernsey*, 115 S. Ct. at 1235. Generally Accepted Accounting Principles are the conventions, rules, and procedures necessary to define accepted accounting practice at a particular time; which includes both broad guidelines and relatively detailed practices and procedures. DAVIDSON ET AL., *supra* note 4, at 747. GAAP consists of three official publications of the American Institute of Certified Public Accountants. *Id.* These publications are the Accounting Principles Board Opinions, the Financial Accounting Standards Board Statements, and the Accounting Research Bulletins. *Id.* See *Mother Francis Hosp. v. Shalala*, 15 F.3d 423, 424 (5th Cir. 1994).

8. *Guernsey*, 115 S. Ct. at 1237. The accrual accounting method is the method of accounting that recognizes revenue as goods are sold (or delivered) and as services are rendered, independent of the time when cash is received. DAVIDSON ET AL., *supra* note 4, at 711. Expenses are recognized in the period when the related revenue is recognized, independent of the time that expenses were met. *Id.* This method of accounting can be contrasted with the cash basis of accounting where revenue is recognized when cash is received and expenses are recognized when the disbursements are made. *Id.* at 721.

9. *Guernsey*, 115 S. Ct. at 1235. The Secretary's authority is derived from 42 U.S.C. § 1395b-1, b-2 (1995).

10. *Id.* at 1234. The Medicare Statute authorizes the Secretary to promulgate regulations "establishing the method or methods to be used" for determining reasonable costs, directing the Secretary in the process to "consider among other things, the principles generally applied by national organizations or established pre-payment organizations (which have developed such principles) in computing reimbursement amounts." *Id.* at 1235. See *infra* note 35 for the text of 42 U.S.C. § 1395x(v)(1)(A) (1988). The Secretary's position was consistent with an informal Medicare reimbursement guideline contained in the Medicare Provider Reimbursement Manual (the "Manual"). *Id.* at 1234. See MEDICARE PROVIDER REIMBURSEMENT MANUAL § 233 (March 1993). The Manual contains a detailed set of policies and guidelines to assist in Medicare reimbursement decisions. *Id.* The Manual provides guidelines and policies to implement Medicare regulations which set forth principles for determining the reasonable cost of provider services furnished under the Health Insurance for the Aged Act of 1965. *Id.* The provisions of the law and the regulations are accurately reflected in the Manual, but do not have the effect of regulations. See *Graham Hosp. Ass'n v. Sullivan*, 832 F. Supp. 1235, 1238 (D.C. Ill. 1993). Section 233 of the Manu-

sought reimbursement for the defeasance loss within one year from its fiscal intermediary, Blue Cross and Blue Shield/Community Mutual Insurance Company (the "Intermediary").<sup>11</sup> Reimbursement was denied based upon the Intermediary's interpretation of section 233 of the Medicare Provider's Reimbursement Manual (the "Manual").<sup>12</sup> Section 233 states that a defeasance loss must be amortized<sup>13</sup> over the term of new bonds.<sup>14</sup> Guernsey appealed the decision to the Provider Reimbursement Review Board (the "PRRB"),<sup>15</sup> which overruled the Intermediary.<sup>16</sup> The Secretary overruled the PRRB and concluded that the defeasance loss must be amortized consistent with the informal administrative guideline of section 233 issued in the Manual.<sup>17</sup> Guernsey brought an action in the United States District Court for the Southern District of Ohio and challenged the reimbursement calculation of its defeasance loss.<sup>18</sup>

The district court held for the Secretary.<sup>19</sup> The district court held that the Secretary was not required to treat a provider's refinancing expense in accordance with GAAP and could instead follow the Manual.<sup>20</sup> The district court also found that the Secretary did not act arbitrarily by refusing to recognize Guernsey's interest account as a funded depreciation amount.<sup>21</sup>

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al requires that the gain or loss on a refunding transaction is to be spread over a number of years. MEDICARE PROVIDER REIMBURSEMENT MANUAL § 233 (March 1993). Section 233 is an interpretation of 42 C.F.R. § 413.9. *Id.*

11. *Guernsey*, 115 S. Ct. at 1234. See 42 U.S.C. § 1395h (1995) for the statutory authority of the Secretary to contract with organizations for the purposes of becoming a Medicare intermediary.

12. *Guernsey*, 115 S. Ct. at 1234.

13. *Id.* Amortization is the allocation of the cost or other basis of an intangible asset over its estimated useful life. BLACK'S LAW DICTIONARY 83 (6th ed. 1990).

14. *Guernsey*, 115 S. Ct. at 1234. See *Guernsey Memorial Hosp. v. Sullivan*, 796 F. Supp. 283, 284 (S.D. Ohio 1992), *modified sub nom. Guernsey Memorial Hosp. v. Secretary of Health & Human Services*, 996 F.2d 830 (6th Cir. 1993), *rev'd sub nom. Shalala v. Guernsey Memorial Hosp.*, 115 S. Ct. 1232 (1995). See also 42 U.S.C. § 1395oo (1995) for details of the full administrative review process for Medicare providers.

15. *Guernsey*, 115 S. Ct. at 1234. See 42 U.S.C. § 1395oo(h) (1995) (establishing Provider Reimbursement Review Boards).

16. *Guernsey*, 115 S. Ct. at 1234.

17. *Id.*

18. *Id.* The district court had jurisdiction of the case under 42 U.S.C. § 1395oo(f)(1) (1995). 42 U.S.C. § 1395oo(f)(1) states in pertinent part: "[T]he Court's review is not de novo but is limited to determining whether the Secretary's action was unsupported by substantial evidence, or was arbitrary or capricious, an abuse of discretion or otherwise not in accordance with law." 42 U.S.C. § 1395oo(f)(1) (1995).

19. *Guernsey*, 796 F. Supp. at 293.

20. *Id.* at 291-92.

21. *Id.* at 284. This issue was not raised on appeal to the United States Su-

On appeal, the Court of Appeals for the Sixth Circuit reversed in part.<sup>22</sup> The court of appeals upheld the district court on the issue of Guernsey's interest account.<sup>23</sup> On the issue of whether the defeasance loss should be amortized, the court of appeals held that the Secretary's interpretation of the Manual was void for lack of notice and failure to follow the comment provision of the Administrative Procedures Act (the "APA").<sup>24</sup> The court of appeals also held that the Secretary was bound to follow GAAP because of the prior reliance of the Secretary on GAAP in other portions of the Manual.<sup>25</sup>

Certiorari was granted by the United States Supreme Court, which identified two issues for review.<sup>26</sup> The first issue was whether general Medicare record-keeping and reporting regulations require that provider costs be reimbursed according to GAAP despite contrary administrative rules issued by the Secretary to govern reimbursement of particular types of costs.<sup>27</sup> The second issue was whether the provision of the Manual on which the Secretary relied in denying reimbursement was invalid as a legislative rule issued without compliance with the notice and comment provisions of the APA.<sup>28</sup>

The majority began its analysis of the case with an interpretation of 42 C.F.R. § 413.20<sup>29</sup> and narrowly interpreted the section as a requirement for the maintenance of the records

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preme Court. *Guernsey*, 115 S. Ct. at 1232.

22. *Guernsey Memorial Hosp. v. Secretary of Health and Human Services*, 996 F.2d 830 (6th Cir. 1993), *rev'd sub nom. Shalala v. Guernsey Memorial Hosp.*, 115 S. Ct. 1232 (1995).

23. *Guernsey*, 996 F.2d at 836.

24. *Id.* at 832. See 5 U.S.C. § 551 (1994). The APA provides for definite procedures that administrative agencies must follow when adopting regulations to implement statutes passed by Congress. *Id.* One of these procedures is the notice and comment provision, which allows interested parties to comment on proposed rule-making before it becomes an administrative rule. *Id.* § 553(c). The court of appeals concluded that the section in the Manual was a substantial change in the regulations and was void by the failure of the agency to comply with the APA in adopting the interpretive guideline. *Guernsey*, 996 F.2d at 832.

25. *Guernsey*, 996 F.2d at 833.

26. *Guernsey*, 115 S. Ct. at 1234.

27. *Id.* Justice Kennedy delivered the opinion of the Court in which Chief Justice Rehnquist and Justices Stevens, Ginsburg, and Breyer joined. *Id.*

28. *Id.*

29. *Id.* at 1235. 42 C.F.R. § 413.20 provides in pertinent part:

The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement.

42 C.F.R. § 413.20 (1993).

to be used in determining the amount of Medicare reimbursement.<sup>30</sup> The majority concluded that the regulation did not require the Secretary to use GAAP in determining the amount of reimbursement, as was urged by Guernsey.<sup>31</sup> The Court stated that the Secretary's position, that § 413.20(a) did not require reimbursement according to GAAP, was supported by the regulation's text and the overall structure of the regulations.<sup>32</sup> The Court noted that this was a reasonable regulatory interpretation to which the Court must defer.<sup>33</sup>

In reaching this conclusion, the majority relied upon previous Supreme Court decisions which had given substantial deference to agency interpretations of an agency's own regulations.<sup>34</sup> Justice Kennedy found support for the Secretary's reading of the regulations in the Medicare Statute.<sup>35</sup> Justice Kennedy also

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30. *Guernsey*, 115 S. Ct. at 1236.

31. *Id.*

32. *Id.*

33. *Id.*

34. *Id.* See generally *Thomas Jefferson Univ. v. Shalala*, 114 S. Ct. 2381, 2386 (1994) (holding that the Secretary's interpretation of the reimbursement regulation was neither clearly erroneous nor inconsistent with the language of the regulation); *Martin v. Occupational Safety and Health Review Comm'n*, 499 U.S. 144, 151 (1991) (holding that a reviewing court should defer to the Secretary of Labor rather than the Occupational Safety and Health Review Commission when each furnish reasonable, but inconsistent interpretations of an ambiguous regulation promulgated by the Secretary of Labor); *Lyng v. Payne*, 476 U.S. 926, 939 (1986) (holding that increased deference is afforded to an agency's interpretation of its own regulations).

35. *Guernsey*, 115 S. Ct. at 1236. See 42 U.S.C. § 1395(x)(v)(1)(A) (1988). Section 1395(x)(v)(1)(A) provides:

The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of

noted that the Secretary is not required to follow GAAP but rather, the statute merely instructs the Secretary to consider adopting methods for reimbursing providers such as those methods generally used by national organizations or established prepayment organizations.<sup>36</sup> The majority further decided that it is not necessary for the Secretary to address every possible reimbursement question, either by default rules or by specification, in the process of making fair reimbursement determinations.<sup>37</sup>

The majority also concluded that the Secretary may issue guidelines which determine the amortization of defeasance losses.<sup>38</sup> The Court reasoned that section 233 of the Manual is appropriate assurance that capital related costs allowable under the regulations are reimbursed in a manner consistent with the statute's mandate that the program bear no more or no less than its fair share of costs.<sup>39</sup> The Court found that the rule issued in section 233 adequately exemplifies the statutory ban on cross-subsidization.<sup>40</sup> This was illustrated by the Secretary's application of section 233 to the facts of the instant case.<sup>41</sup>

The Supreme Court concluded that section 233 of the Manual should be treated as an interpretive rule for APA purposes.<sup>42</sup>

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charges or a percentage of charges where this method reasonably reflects the costs. Such regulation shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

*Id.* (emphasis added).

36. *Guernsey*, 115 S. Ct. at 1237.

37. *Id.*

38. *Id.*

39. *Id.*

40. *Id.* at 1238. See *St. Mary of Nazareth Hosp. Ctr. v. Schweiker*, 718 F.2d 459 (1983) (holding that section 233 is meant to prevent the Medicare program from subsidizing non-Medicare related costs and equally clearly proscribes Medicare from being subsidized by non-Medicare sources).

41. *Guernsey*, 115 S. Ct. at 1238. The Secretary reasoned that amortization was required to avoid the statutory ban of 42 U.S.C. § 1395x(v)(1)(A) on cross-subsidization because the loss was derived over a significant time period from patient services. *Id.*

42. *Id.* at 1239.

The Court recognized that interpretive rules do not require notice and comment and that as such, interpretive rules are not legally binding.<sup>43</sup> The majority believed that the rulemaking required by the APA would be necessary if the interpretive rule led to the adoption of a position incompatible with existing regulations.<sup>44</sup> The Supreme Court, in contrast to the Court of Appeals for the Sixth Circuit, concluded that section 233 did not create a substantial change in the regulations.<sup>45</sup>

The United States Supreme Court decided by a five to four vote that the Secretary is not bound to use GAAP in applying a method to determine appropriate levels of reimbursement to providers.<sup>46</sup> The Court stated that GAAP was not necessarily economically realistic and that if the Court were to impose upon the Secretary the duty to adopt GAAP, then the Secretary would have to undergo a rigorous rulemaking process each time a disagreement with GAAP arose on a reimbursement issue.<sup>47</sup> The Court also concluded that GAAP is a varied collection of conventions, rules and procedures that define the acceptable accounting practices that presently exist.<sup>48</sup> The majority concluded that there was no intention on the Secretary's part to interpret various sources of GAAP in developing interpretive rules on the timing of Medicare reimbursement.<sup>49</sup>

The Court noted that the procedures followed in *Guernsey* are illustrative of a workable framework for the highly complex Medicare reimbursement process.<sup>50</sup> The Court reasoned that the Secretary's statutory duties had been fulfilled when regulations had been promulgated setting forth the basic methods of reimbursement and when interpretive rules had been issued to advise providers on the application of the Medicare statute relating to reimbursement claims.<sup>51</sup> Because the Secretary is not bound to make Medicare reimbursements in accordance with GAAP, the Court stated that the requirements of section 233 that bond defeasance losses be amortized did not amount to a substantive change in the regulations.<sup>52</sup>

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43. *Id.*

44. *Id.*

45. *Id.* (citing *Guernsey v. Secretary of Health and Human Services*, 996 F.2d 830, 832 (1993), *rev'd sub nom.* *Shalala v. Guernsey Memorial Hosp.*, 115 S. Ct. 1232 (1995)).

46. *Guernsey*, 115 S. Ct. at 1239.

47. *Id.*

48. *Id.*

49. *Id.*

50. *Id.*

51. *Guernsey*, 115 S. Ct. at 1240.

52. *Id.*



Section 233 was found to be a valid interpretive rule and thus, the Secretary's reliance on the rule to deny Guernsey's claim for full reimbursement of its defeasance loss in 1985 was considered to be appropriate.<sup>53</sup> In so doing, the United States Supreme Court reversed the decision of the Court of Appeals for the Sixth Circuit and held that it was proper to amortize Guernsey's defeasance loss over the remaining term of the old bond issue.<sup>54</sup>

Justice O'Connor, in a dissenting opinion, focused on the timing of the reimbursement.<sup>55</sup> Justice O'Connor acknowledged that the Court must give deference to an agency's interpretation of its own regulations.<sup>56</sup> However, Justice O'Connor stated that the Court could not sustain an agency's interpretation of its regulations if the interpretation is erroneous or inconsistent with the underlying purpose of the regulations promulgated by the agency.<sup>57</sup> Justice O'Connor believed that the intent of the Medicare Statute was such that the Secretary would state the applicable reimbursement mechanisms in the regulations.<sup>58</sup> According to Justice O'Connor, default rules covering a spectrum of situations should be included in the regulations until such time as specific regulations are promulgated regarding particular types of costs.<sup>59</sup> The dissent found that in 42 C.F.R. § 413.20, the Secretary adopted GAAP as a default rule for reimbursement in situations such as that in *Guernsey*.<sup>60</sup> As support for her premise, Justice O'Connor noted the widespread use of GAAP in other health care institutions.<sup>61</sup> Justice O'Connor also considered it to be significant that hospitals reporting to Medicare follow GAAP in cost reporting functions.<sup>62</sup> Justice O'Connor noted that there must be some consistency between the functions of cost reporting and cost reimbursement.<sup>63</sup> Justice O'Connor found such a link in 42 C.F.R. § 413.20,<sup>64</sup> which states that a provider hospital

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53. *Id.*

54. *Id.* at 1237, 1240.

55. *Id.* at 1240 (O'Connor, J., dissenting). A dissenting opinion was filed by Justice O'Connor who was joined by Justices Scalia, Souter and Thomas. *Id.*

56. *Guernsey*, 115 S. Ct. at 1240. See *Lyng v. Payne*, 476 U.S. 926, 939 (1986) (holding that an agency's own interpretation of its regulations is entitled to substantial deference).

57. *Guernsey*, 115 S. Ct. at 1240.

58. *Id.*

59. *Id.* at 1241.

60. *Id.* at 1241-42.

61. *Id.* at 1241.

62. *Guernsey*, 115 S. Ct. at 1241.

63. *Id.* at 1242.

64. *Id.* 42 C.F.R. § 413.20(d) provides:

The principles of cost reimbursement require that providers maintain sufficient

generally need not modify its accounting and reporting practices in order to determine what costs Medicare will cover.<sup>65</sup> In conclusion, Justice O'Connor interpreted 42 C.F.R. § 413.20 to require that in the absence of a regulation concerning the specific reimbursement transaction requested by the provider, Medicare providers must be reimbursed according to GAAP.<sup>66</sup> The dissent also found no insurmountable problems inherent in the APA which the Secretary could not meet in promulgating regulations, because Congress believed the Secretary could meet the challenge.<sup>67</sup> Justice O'Connor believed that the situation present in this case was foreseen by the Secretary and should have been addressed directly by a regulation.<sup>68</sup>

The dissent concluded that the Secretary's reimbursement decision could not be rationalized as a valid application of the existing regulations.<sup>69</sup> In the dissent's view, Guernsey's basis for reimbursement for its advance refunding costs was derived from GAAP and the Secretary's published regulations.<sup>70</sup> The dissent noted that the Secretary's application of section 233, which denied Guernsey's request, was a departure from GAAP.<sup>71</sup> The dissent noted that the reimbursement decision was contrary to the agency's own regulations and therefore was "not in accordance with law" within the meaning of the APA.<sup>72</sup>

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financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained to arrive at equitable and proper payment for services to beneficiaries.

42 C.F.R. § 413.20(d) (1994).

65. *Guernsey*, 115 S. Ct. at 1242.

66. *Id.* at 1243.

67. *Id.*

68. *Id.*

69. *Id.* at 1245.

70. *Guernsey*, 115 S. Ct. at 1245.

71. *Id.*

72. *Id.* See 5 U.S.C. § 706 (1994). Section 706 provides in pertinent part: To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The reviewing court shall—

(1) compel agency action unlawfully withheld or unreasonably delayed; and  
(2) hold unlawful and set aside agency action, findings, and conclusions found to be—

(A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;

(B) contrary to constitutional right, power, privilege, or immunity;

The dissent agreed with the court of appeals that there is a strong correlation between cost reporting and cost reimbursement regulations and this correlation is too strong to be made ineffective by a rule not adopted in accordance with the rulemaking provisions of the APA.<sup>73</sup> Justice O'Connor concluded that the interpretive rule announced in section 233 of the Manual should be declared invalid.<sup>74</sup>

Historically, Medicare was developed as a federal insurance program that provides for the medical and hospitalization costs of the elderly.<sup>75</sup> The Medicare statutes have been incorporated into the Social Security sections of the United States Code.<sup>76</sup> In the statutes, the Secretary has been directed to make regulations to implement the applicable statutes passed by Congress concerning the Medicare program.<sup>77</sup> One of the requirements directs the Secretary to pay the lesser of customary or reasonable cost of any services provided for beneficiaries of the Medicare program.<sup>78</sup> A reasonable cost is defined as the actual incurred cost less any cost found to be unnecessary in the efficient delivery of health services.<sup>79</sup>

(C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;

(D) without observance of procedure required by law;

(E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or

(F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error.

*Id.*

73. *Guernsey*, 115 S. Ct. at 1245-46.

74. *Id.* at 1240.

75. See ANTHONY R. KOVNER ET AL., *JONAS'S HEALTH CARE DELIVERY IN THE UNITED STATES* 327 (5th ed. 1995). In 1993 Medicare had 36,300,000 enrollees and expenses of \$150,370,000,000 for benefits paid to providers of services. U.S. DEPT OF HEALTH & HUMAN SERVICES, NATIONAL CENTER FOR HEALTH STATISTICS 243 (1994).

76. See 42 U.S.C. § 1395 (1988).

77. See 42 U.S.C. §§ 1395b-1(a)(1)(B), 1395b-2 (1988 & Supp. V 1993).

78. See 42 U.S.C. § 1395f(b)(1) (1988). Section 1395f(b)(1) states in pertinent part: The amount paid to any provider of services . . . with respect to services for which payment may be made under this part shall be . . . the lesser of (A) the reasonable cost of such services as determined by section 1395x(v) of this title and as further limited by section 1395oo(b)(2) of this title, or (B) the customary charges with respect to such services.

*Id.*

79. See 42 U.S.C. § 1395x(v)(1)(A) (1988). Section 1395x(v)(1)(A) provides in pertinent part:

[T]he Secretary shall consider, among other things, the principles generally applied by national organizations or established pre-payment organizations

From the initiation of the Medicare program until 1983, hospitals were paid based on the actual costs incurred in providing services.<sup>80</sup> In 1983, Congress enacted legislation which created the Prospective Payment System (the "System").<sup>81</sup> Under the System, hospitals are paid a fixed amount based on the diagnosis of the hospitalized patient.<sup>82</sup> Because of this change, hospitals are no longer reimbursed on the actual costs incurred in providing services.<sup>83</sup> However, extraordinary items such as the defeasance loss at issue in *Guernsey* are still compensable to the extent that they do not violate the cross-subsidization provision of 42 U.S.C. § 1395x(v).<sup>84</sup>

The process of receiving information from the providers of health care services under the Medicare program and the payment for these services by the federal government is known as the reimbursement process.<sup>85</sup> The regulations developed by the Secretary to accomplish this task are contained in 42 C.F.R. § 413.<sup>86</sup> The two sections at issue in *Guernsey* are the sections pertaining to the cost data that must be forwarded to the Secretary and the system of accounting that must be used by the Secretary in computing the amounts due the provider.<sup>87</sup> These sections were interpreted by the agency in the form of interpretive rulings which are contained in the Manual.<sup>88</sup>

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(which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers.

*Id.*

80. Douglas E. Cressler, *Medicare Provider Reimbursement Disputes: Mapping the Contorted Borders of Administrative and Judicial Review*, 26 SOC. SECURITY REP. SER. (West) 741, 742 (1989).

81. See generally 42 U.S.C. § 1395ww (1988 & Supp. V 1993) (establishing payment to hospital providers under the System). See also KOVNER ET AL., *supra* note 75, at 142 (discussing the impact of the System on Medicare reimbursement to hospitals).

82. Cressler, *supra* note 80, at 742. The payments to health care providers are based upon diagnosis related groupings ("DRG's"). *Id.*

83. *Id.*

84. See *supra* note 35 for a description of the costs reimbursable under the System.

85. The Medicare program itself is under the guidance of the Health Care Financing Administration (the "HCFA"). KOVNER ET AL., *supra* note 75, at 327. The HCFA contracts with intermediary organizations in each region of the United States to provide for claims processing and payment of claims that are due providers under the Medicare program. *Id.* Providers submit claims directly to the intermediaries and are paid based on the information that they provide. *Id.*

86. See 42 C.F.R. § 413 (1994).

87. *Guernsey*, 115 S. Ct. at 1234.

88. See *supra* note 10 for a discussion of applicable statutes relating to the Secretary's authority to issue interpretive rulings.

The United States Supreme Court addressed the issue of reimbursement within the Medicare statutes in *Bethesda Hospital Association v. Bowen*.<sup>89</sup> In *Bethesda*, a group of hospitals challenged a determination by the PRRB that it lacked jurisdiction to decide the merits of the group's claim concerning reimbursement for malpractice premium costs paid by providers in the group.<sup>90</sup> The providers, in cost reports submitted to the fiscal intermediary for 1980, followed a 1979 regulation of the Secretary that disallowed portions of the costs by Medicare providers.<sup>91</sup> The group then filed for a hearing before the PRRB to challenge the validity of the 1979 regulation.<sup>92</sup> The PRRB held that the hearing did not fall within its statutory jurisdiction.<sup>93</sup> The PRRB held that its authority to grant hearings is limited to situations in which a provider is dissatisfied with a final determination of the fiscal intermediary.<sup>94</sup> The PRRB reasoned that the providers in the group could not be dissatisfied because they had submitted a cost report according to Medicare guidelines, thus effecting a self-disallowance of the claims.<sup>95</sup>

The district court disagreed and held that the PRRB should have exercised jurisdiction over the matter.<sup>96</sup> The Secretary appealed the district court's ruling to the Sixth Circuit Court of Appeals, which reversed the district court.<sup>97</sup> The court of appeals based its determination upon previous decisions in this area.<sup>98</sup> The United States Supreme Court granted certiorari to resolve the conflict among the circuit courts on the matter and ultimately reversed, in part, the decision of the court of appeals.<sup>99</sup>

Justice Kennedy, writing for a unanimous Court, looked to the "plain meaning" of the statute granting jurisdiction to the PRRB and determined that the PRRB had jurisdiction to resolve the

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89. 485 U.S. 399 (1988).

90. *Bethesda*, 485 U.S. at 401.

91. *Id.*

92. *Id.*

93. *Id.* at 402.

94. *Id.*

95. *Bethesda*, 485 U.S. at 402.

96. *Bethesda Hosp. v. Heckler*, 609 F. Supp. 1360, 1368 (S.D. Ohio 1985), *rev'd in part sub nom. Bethesda Hosp. v. Secretary of Health and Human Servs.*, 810 F.2d 558 (6th Cir. 1987), *rev'd in part sub nom. Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988).

97. *Bethesda Hosp. v. Secretary of Health and Human Servs.*, 810 F.2d 558, 559-60 (6th Cir. 1987), *rev'd in part sub nom. Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988).

98. *Bethesda*, 810 F.2d at 561.

99. *Bethesda*, 485 U.S. at 402.

issues presented by the providers in the group.<sup>100</sup> The Secretary contended that the providers in the group could not have been dissatisfied with the information contained in the cost report which disallowed the amount.<sup>101</sup> The Secretary argued that because the providers in the group did not ask for the amounts in the cost report as submitted to the intermediary, the providers in the group could not argue with the amount that the intermediary reimbursed.<sup>102</sup> The Supreme Court rejected this argument, holding that supplying a cost report in full compliance with the dictates of the Secretary did not bar the providers in the group from challenging the amount of reimbursement.<sup>103</sup> Finding different roles for the intermediary and the PRRB, the Court held that even though the PRRB could not rule on its own that the Secretary's regulation was invalid, the PRRB could certainly impact the judicial review.<sup>104</sup>

In *Bowen v. Georgetown University Hospital*,<sup>105</sup> the United States Supreme Court affirmed the decision of the Court of Appeals of the District of Columbia and held that the Secretary had no statutory authority to engage in retroactive rulemaking.<sup>106</sup> In *Georgetown*, the Secretary developed a schedule for calculating cost limits.<sup>107</sup> Various hospitals brought suit in the District Court of the District of Columbia and the district court invalidated the Secretary's rule.<sup>108</sup> The district court's decision was not appealed by the Secretary, but subsequently the Secretary published a notice seeking public comment to reissue the original cost limit rule.<sup>109</sup>

In the same year that the Secretary published the reissue notice, Congress amended the Medicare Act, providing for a Prospective Payment System, thus rendering any prospective application of the rule proposed by the Secretary moot except for

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100. *Id.* at 403. See 42 U.S.C. § 1395oo(a). Section 1395oo(a) provides in pertinent part: "[A] provider . . . may obtain a hearing before the board with respect to [its] cost report if . . . (1) such provider is (A)(1) dissatisfied with a final determination of . . . its fiscal intermediary . . . as to the amount of total program reimbursement due the provider . . . for the period covered by such report." *Id.* See *INS v. Cardoza-Fonseca*, 480 U.S. 421, 431 (1987); *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984) (cases holding that a reviewing court should look to the plain meaning of a statute under review).

101. *Bethesda*, 485 U.S. at 402.

102. *Id.* at 404.

103. *Id.*

104. *Id.* at 406-07.

105. 488 U.S. 204 (1988).

106. *Georgetown*, 488 U.S. at 215-16.

107. *Id.* at 206.

108. *Id.*

109. *Id.* at 207.

a fifteen month period prior to the new amendment to Medicare.<sup>110</sup> The Secretary, after considering the comments received, reissued the original rule and subsequently attempted to recoup the monies paid to the hospitals in excess of the cost limit as though the original rule had never been invalidated.<sup>111</sup> The hospitals which benefitted by the invalidation of the original rule by the district court exhausted their administrative appeals and sought judicial relief, claiming that the retroactive cost schedule was invalid under Medicare and the APA.<sup>112</sup> The District Court of the District of Columbia granted summary judgment for the hospitals and the decision was appealed by the Secretary to the court of appeals, which affirmed the district court.<sup>113</sup> The court of appeal's decision was appealed to the United States Supreme Court, which granted certiorari and affirmed.<sup>114</sup>

Acknowledging that retroactivity is not favored in the law, the Court stated that congressional enactments and administrative rules should not be given retroactive effect unless the language required that result.<sup>115</sup> The majority also stated that even in such a situation, courts should be reluctant to find such authority absent a specific statutory grant.<sup>116</sup> The Secretary contended that various sections of the Medicare Act provide for the authority to make retroactive adjustments such as the one proposed.<sup>117</sup> The Court held that there is no specific statutory authority for the Secretary to engage in indirect retroactive rulemaking and affirmed the court of appeals.<sup>118</sup>

In *Good Samaritan Hospital v. Shalala*,<sup>119</sup> several rural hospitals brought an action against the Secretary and sought reclassification as urban hospitals and retroactive reimbursement amounts appropriate to that reclassification.<sup>120</sup>

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110. *Id.*

111. *Georgetown*, 488 U.S. at 207.

112. *Id.*

113. *Id.* at 207-08.

114. *Id.* at 208.

115. *Id.*

116. *Georgetown*, 488 U.S. at 208.

117. *Id.* at 209.

118. *Id.* at 215-16.

119. 113 S. Ct. 2151 (1993).

120. *Good Samaritan*, 113 S. Ct. at 2156. Under the Medicare reimbursement structure, hospitals are paid different amounts based upon whether they are in rural or urban areas. *Id.* This difference is based upon whether the facility is located within a Standard Metropolitan Statistical Area ("SMSA"). *Id.* at 2155. "A SMSA is a large population center and neighboring communities that are highly integrated economically and socially with that center." PAUL J. FELDSTEIN, *HEALTH CARE ECONOMICS* 50 (3d ed. 1988). For Medicare purposes, rural areas are areas outside of a

The hospitals filed an appeal with the PRRB challenging the cost limits imposed on the hospitals.<sup>121</sup> The PRRB held that it lacked the authority to grant the relief requested and granted the hospital's request for expedited judicial relief.<sup>122</sup> The District Court for the District of Nebraska held for the hospitals and reasoned that the statute requires the payment of all costs shown to be reasonable regardless of whether the hospitals surpassed the amount calculated under the cost limit schedule developed by the Secretary.<sup>123</sup> The Court of Appeals for the Eighth Circuit reversed the district court,<sup>124</sup> basing its decision on the Supreme Court's decision in *Georgetown*, which prohibits retroactive rulemaking by administrative agencies.<sup>125</sup> The United States Supreme Court granted certiorari to resolve a conflict among the circuits on this question.<sup>126</sup>

The Court began its analysis with the rule announced in *Chevron U.S.A., Inc. v. National Resources Defense Council*<sup>127</sup> regarding the interpretation of statutes. The Court then determined that the clause at issue was ambiguous and capable of being interpreted to the benefit of either party.<sup>128</sup> In this type of situation, the Court emphasized that the rule announced in *National Railroad Passenger Corp. v. Boston & Maine Corp.*<sup>129</sup> applied. The *National Railroad* Court held that when a statute is capable of two different interpretations, the Court will rely upon the interpretation that is espoused by the agency entrusted with the interpretation of the statute.<sup>130</sup> The Court held that there was an adequate basis for the regulations developed by the Secretary that mandates the cost limits imposed on the hospital providers and reversed the Eighth Circuit Court of Appeal's decision.<sup>131</sup>

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SMSA which do not have within the region of greater than 50,000 population or an area with a total metropolitan population of less 100,000. KOVNER ET AL., *supra* note 75, at 170.

121. *Good Samaritan*, 113 S. Ct. at 2156.

122. *Id.* See 42 U.S.C. § 1395oo(f)(1) (1995) (allowing expedited judicial relief in the Medicare appeals process).

123. *Good Samaritan*, 113 S. Ct. at 2156.

124. *Good Samaritan Hosp. v. Sullivan*, 952 F.2d 1017 (8th Cir. 1991), *rev'd sub nom.* *Good Samaritan Hosp. v. Shalala*, 113 S. Ct. 2151 (1993).

125. *Good Samaritan*, 113 S. Ct. at 2156.

126. *Id.* at 2157.

127. 467 U.S. 837, 842-45 (1984) (holding that if the intent of Congress in creating a statute is clear, the matter of statutory interpretation for the courts is ended).

128. *Good Samaritan*, 113 S. Ct. at 2157-58.

129. 503 U.S. 407 (1992).

130. *Good Samaritan*, 113 S. Ct. at 2159.

131. *Id.* at 2160. The Court also found unpersuasive the hospitals' argument



In *Thomas Jefferson University v. Shalala*,<sup>132</sup> the Court announced that a court reviewing a decision of the Secretary must defer to the Secretary's interpretation of a regulation unless an alternative reading is compelled by the regulation's plain language or by other indications of the Secretary's intent at the time of the regulation's promulgation.<sup>133</sup>

In *Thomas Jefferson*, a teaching hospital challenged the decision of a fiscal intermediary to deny certain teaching costs associated with the hospital's mission.<sup>134</sup> The PRRB reversed the intermediary's decision, thus allowing reimbursement for the hospital.<sup>135</sup> The decision was then overturned by the Secretary, who reinstated the fiscal intermediary's original decision.<sup>136</sup> The hospital filed for review in the District Court for the Eastern District of Pennsylvania, where the Secretary's decision was upheld on summary judgment.<sup>137</sup> The Third Circuit Court of Appeals affirmed the district court.<sup>138</sup> The United States Supreme Court granted certiorari and affirmed the decision in favor of the Secretary.<sup>139</sup> The Court found that the Secretary's decision followed the intent of Congress that Medicare funds should not be used to subsidize educational activities as opposed to patient care activities and that the Secretary's interpretation was reasonable and deserved deference.<sup>140</sup>

In *Mother Francis Hospital v. Shalala*,<sup>141</sup> the Fifth Circuit Court of Appeals addressed the issue of whether a defeasance loss should be reimbursed in the year it was incurred.<sup>142</sup> In *Mother Francis*, a hospital retired bonded debt through issuance

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concerning the shifting views of the administrative agency charged with implementation. *Id.* The Court stated that there had been a change in the manner in which the agency desired matters such as the one involved in the case to be handled over the previous ten years. *Id.* The Court stated: "[A]n administrative agency is not disqualified from changing its mind; and when it does, the courts still sit in review of the administrative decision and should not approach the statutory construction issue de novo and without regard to the administrative understanding of the statutes." *Id.* at 2161.

132. 114 S. Ct. 2381 (1994).

133. *Thomas Jefferson*, 114 S. Ct. at 2389.

134. *Id.*

135. *Id.*

136. *Id.*

137. *Thomas Jefferson Univ. v. Sullivan*, No. Civ.A.90-2036, 1992 WL 99618, at \*1 (E.D. Pa. 1992), *aff'd sub nom. Thomas Jefferson Univ. v. Shalala*, 993 F.2d 879 (3d Cir. 1993), *aff'd*, 114 S. Ct. 2381 (1994).

138. *Thomas Jefferson Univ. v. Shalala*, 993 F.2d 879 (3d Cir. 1993), *aff'd*, 114 S. Ct. 2381 (1994).

139. *Thomas Jefferson*, 114 S. Ct. at 2383.

140. *Id.* at 2384.

141. 15 F.3d 423 (5th Cir. 1994).

142. *Mother Francis*, 15 F.3d at 424.

of new bonds and incurred a defeasance loss.<sup>143</sup> The hospital's request for reimbursement was denied by a fiscal intermediary.<sup>144</sup> The PRRB reversed the intermediary, holding that in the absence of specific regulations, GAAP controls the reimbursement process.<sup>145</sup> The Secretary reversed the PRRB, holding that section 233 of the Manual controlled the issue.<sup>146</sup> The Secretary's decision was appealed by the hospital to a magistrate judge of the District Court for the Eastern District of Texas, who issued a report and recommendation in favor of the hospital.<sup>147</sup> The magistrate found that section 233 was a manual provision without the force and effect of law and was thus ineffective to change the meaning of the governing regulations calling for GAAP.<sup>148</sup> The recommendation was rejected by the district court, which found that section 233 is an interpretive rule of the regulations and is therefore a valid rule.<sup>149</sup> The district court granted summary judgment for the Secretary and the hospital appealed.<sup>150</sup>

The Court of Appeals for the Fifth Circuit began its analysis by reviewing the applicable statutes for reimbursement of reasonable costs incurred by providers in providing services to Medicare beneficiaries.<sup>151</sup> The court noted that every other court, except the district court in this case, had rejected the Secretary's contention that the regulations only call for GAAP in the reporting function of a provider's report and that the regulations do not call for GAAP in the reimbursement process.<sup>152</sup> The Fifth Circuit noted the Sixth Circuit's decision in *Guernsey* when it echoed *Guernsey's* holding by stating that the connection between cost reporting and cost reimbursement is too strong to be broken by a rule not adopted in accordance with the notice and comment provisions of the APA.<sup>153</sup> The Court also distinguished the case of *Sun Towers, Inc. v Heckler*<sup>154</sup> from *Guernsey* because in *Guernsey*, there was no question about whether the incurred cost was allowable within the Medicare

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143. *Id.*

144. *Id.* at 425.

145. *Id.*

146. *Id.*

147. *Mother Francis*, 15 F.3d at 425.

148. *Id.*

149. *Id.*

150. *Id.*

151. *Id.* at 426.

152. *Mother Francis*, 15 F.3d at 426.

153. *Id.* at 427.

154. 725 F.2d 315 (5th Cir.) (holding that GAAP is not necessarily to be used in determining if a particular cost is allowable), *cert. denied*, 469 U.S. 823 (1984).

Statute.<sup>155</sup> Adopting *Guernsey*, the Fifth Circuit held for the hospital provider and reversed the decision of the district court.<sup>156</sup>

The United States Supreme Court's decision in *Guernsey* affirmed the earlier holdings of the Supreme Court with respect to the deference to be given to rulings of administrative agencies. The dispute in *Guernsey* centered on whether the regulations require GAAP to be used in all aspects of the financial reimbursement process of Medicare.<sup>157</sup> While the Court and the Secretary agreed that the applicable provisions of the regulations only pertain to the cost reporting function, it left providers speculating as to what methods should be applied in computing the amount of reimbursement for items related to interest expense and capital losses.<sup>158</sup> This type of uncertainty leads to apprehension when one considers the significant role that Medicare plays in a healthcare provider's revenue stream.<sup>159</sup> It is a reasonable conclusion that this type of uncertainty with regard to a major source of revenue would lead providers to cache funds until the uncertainty is resolved. The cached funds could be better utilized to provide needed healthcare services to the eligible population.

One commentator has found the *Guernsey* decision as an implication that the current regulations pertaining to Medicare are perceived to be sufficient to the Court, and if gaps exist within the regulations the Secretary need not promulgate any additional regulations because the gaps in the regulations are being filled with interpretive manuals or administrative appeal rulings.<sup>160</sup> Professor Barry opines that providers can look forward to *Guernsey* being "quoted again and again" in future litigation challenging actions taken pursuant to the HCFA's interpretive manuals.<sup>161</sup> Professor Barry further believes that providers will have no idea what rules will apply by default when there is no apposite Medicare regulation.<sup>162</sup>

The Court also viewed as too cumbersome the process described in the APA interpretive rulings as it related to the complex world of health care reimbursement. Even though the

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155. *Mother Francis*, 15 F.3d at 427.

156. *Id.*

157. *Guernsey*, 115 S. Ct. at 1234.

158. See Barry, *supra* note 2, at 6.

159. In 1993, Medicare accounted for over 56% of the revenues received by hospitals in the United States. See KOVNER ET AL., *supra* note 75, at 328.

160. See Barry, *supra* note 2, at 5.

161. *Id.* See KOVNER ET AL., *supra* note 75, at 327.

162. Barry, *supra* note 2, at 5.

Department of Health and Human Services technically won in *Guernsey*, on June 27, 1995, the Secretary issued a final rule clarifying the accrual basis of accounting with regard to Medicare reimbursement of various other provider costs.<sup>163</sup> Under the new rule, expenses must be incurred by a health care provider before Medicare will pay its share of the expenses.<sup>164</sup> In giving regulatory support to what the HCFA viewed as its longstanding policy; the HCFA hoped to decrease the opportunity of a successful challenge to its policy.<sup>165</sup> The new rule also creates a new subsection for the accrual provisions.<sup>166</sup> The stated reasons for this are to eliminate confusion among providers and give recognition to the distinction between GAAP in cost reporting by providers and the determination of allowable costs under the Medicare statute.<sup>167</sup> This is a much needed positive step in reducing provider reimbursement concerns.

One may conclude that *Guernsey* may be inconsequential in United States Supreme Court jurisprudence, but the *Guernsey* decision did motivate one administrative agency into formalizing its interpretive rules into regulations in order to reduce the confusion of health care providers in the Medicare reimbursement process.

Eugene A. Vittone II

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163. See 60 Fed. Reg. 33,126 (1995) (to be codified at 42 C.F.R. pt. 413).

164. See *HCFA Issues Final Rule Clarifying Accrual Accounting for Reimbursement*, Health Care Daily (BNA) (June 28, 1995) [hereinafter *HCFA*].

165. *HCFA*, *supra* note 164.

166. *Id.*

167. *Id.*

